

Wednesday, February 26, 2014

Attention: Committee on Public Health, Connecticut Legislature

Re: Governor's Bill No. 36, LCO No. 249, An Act Concerning the Governor's Recommendations to Improve Access to Health Care

My name is Henry Schneiderman. I am an internist-geriatrician, and here offer my intense and unreserved support of Governor's Bill No. 36, LCO No. 249, An Act Concerning the Governor's Recommendations to Improve Access to Health Care. An essential feature of this bill removes the requirement that advance practice registered nurses (APRNs) have a written collaborative practice agreement with a licensed physician after a three-year period post training of such collaborative practice. Safe patient care does not require any such collaborative agreement nor the kind of consultation it stipulates, a kind of consultation that in fact is not universally practiced, typically because of failure by a physician to do so. By virtue of my own continuous collaboration with APRNs over the past 19 years, and by my serving on the Scope of Practice Committee of the CT Department of Public Health, whose report you will have seen, I recognize that collaboration occurs continuously between healthcare professionals. This is because we all seek insights from other professionals and consultants. The piece of paper that is the agreement does not ensure this essential function, and collaboration occurs without it, for instance, when I ask another MD, "What do you think about this presentation? Are there other diagnoses you'd consider, or other tests?"

APRNs have proven their efficacy and dedication for decades. They are highly vigilant to minimize patient risks. APRNs know when to consult: Just as I can take care of 95% of the kidney problems of my patients without a nephrologist, so too an APRN can render superb care, using her or his training and experience, for more than 95% of issues that ail her or his patients. Just as when a seasoned physician like myself knows well when to obtain consultation, so too does the APRN--if anything, and especially early in career, they will bend over backwards if in any doubt whatever, to check with someone who may know more--and that may be another APRN as well as an MD. The overlay of regulation burdens time and efficiency, and conveys inappropriate disrespect.

The requirement for a collaborative practice agreement becomes a major barrier for APRN practice because often there are no physicians willing and available for collaboration. Some doctors resist augmenting the scope of APRNs, viewing them as "unfair" economic competitors. That posture ignores the accepted reality that the present undersupply of primary care physicians will worsen sharply for decades to come, due to economic disincentives, overwork, lack of respect from hospitals, employers, insurers, pharmacies and the public, as experienced by every primary care practitioner. The care and health of human beings depend heavily on APRNs, and access to both primary and specialty care will require APRNs in an expanded role, to an increasing degree going forward. This reality is most striking in domains of medicine that lack reimbursable procedures, since current fee structure rewards procedures (including those of little or no benefit) and undercompensates cognitive services, time spent with patients, meticulous physical examination and a comprehensive approach to

the biopsychosocial needs of patient and patient-family unit. Yet those intense professional efforts define good primary care internal medicine, mental health care, primary care pediatrics, and my own area of specialization, geriatric care of frail elders whether in community or in a nursing home. Each of the above is an area where APRNs shoulder a disproportionately large share of the clinical workload, to their eternal credit.

Experience working daily with APRNs informs my opinion: I have collaborated closely in care of patients in long-term care and in hospital with both geriatric and geropsychiatric APRNs, and have long taught in Yale's APRN program. APRNs show consistent admirable willingness "to get their hands dirty" and to meet the patient where he or she lives – physically, medically, emotionally. My intense respect for APRNs includes a deep sense of trust. The APRNs at my workplace and I complete Collaborative Agreements per regulation, but we talk about patients together for the same reason that I talk with my physician colleagues: mutual regard, and recognition that insight flows in more than one direction. A cohesive team takes better care of a human being more effectively than any single individual, regardless of title.

I am proud to be a physician and feel confidence in my long training; but I'd be a fool to undervalue the post-training clinical experiences that mold any health care worker. The psychosocial skills of APRNs and their hands-on approach recall what used to be most highly prized in physicians; such skills have eroded among physicians to the detriment of patient care and of the prestige of physicians. APRNs represent a vital force in the reinstatement of best practices and values. They provide a counterweight to some runaway costs in health care (though medications, procedures and long-term care cost our society far more than all provider billings).

The research record is very clear in the 17 states (and the District of Columbia) which have long empowered APRNs to practice independently: access is improved, costs are lower, and quality is not diminished in the least. As part of my work on the Scope of Practice Committee, I very studiously critiqued two papers cited by those who assert to the contrary; my reviews, which I would be happy to share with you electronically if you like, revealed that the data in these papers did not support the conclusions drawn by their authors.

I respect the Connecticut State Medical Society and am proud to have been and to remain a member of it for three decades. But each of the specific reasons cited in their literature opposing this bill is unconvincing, erroneous or not relevant: for example, APRNs acknowledge that their training is not as lengthy as that of physicians, but that training is demonstrably sufficient to support equal patient outcomes. If there are limited dollars to cover the staggering health costs of our population, why would we NOT welcome a solution that costs less, preserves quality, and enhances access? Why would we NOT accept the verdict of those impartial researchers who have shown, again and again in the health services journals, that nurse practitioners are fully up to independent practice? Why would we not listen to the many states that have successfully walked this path before us?

Our health-care system will operate more efficiently and effectively once we acknowledge, empower, license and support APRN practices that function without physician presence. Intense fiscal pressures on the health care system support this conclusion. So does the issue of provider supply: consider Massachusetts, and the impact of universal coverage without enough primary care providers; and the result when too many physicians refuse to enroll ill-remunerative patients on Medicaid. APRNs represent an indispensable element in achieving universal health care rather than a repellent two-tier health system. To realize any such noble vision, we need a system that does not break the bank of local, state and federal budgets; APRNs are a large part of the solution. There is every reason to welcome their needed and effective presence and practice to the full extent of their training and capacity, and no down side. I urge you on behalf not only of all health care workers in CT, but of our citizens and residents, to enact the Governor's Bill.

Sincerely and respectfully,

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